Complaint No: _____ Date Received: _____

KENTUCKY BOARD OF LICENSURE FOR OCCUPATIONAL THERAPY

Complaint Form

Person Filing Complaint

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Day Phone: ( ) - Evening Phone: ( ) -

Patient Information

Name and Description: _____

Name of Occupational Therapist or Occupational Therapy Assistant

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Day Phone: ( ) - Evening Phone: ( ) -

Name and phone number of person(s) who may provide additional information

1. Name:		**Phone #:**	**( ) -**	**Type of information:**	
2. Name:		**Phone #:**	**( ) -**	**Type of information:**	
3. Name:		**Phone #:**	**( ) -**	**Type of information:**	
4. Name:		**Phone #:**	**( ) -**	**Type of information:**	

Brief Summary of Complaint

(Please be specific as possible regarding names, dates, locations, and action which you believe to be improper, unethical or unprofessional. Please attach copies of any documents or records pertinent to your complaint.)

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By signing this complaint form, I hereby certify that the information is complete and true to the best of my knowledge.

Signature: _____ Date: _____

Send to : KY Board of Licensure for OT
PO Box 1360
Frankfort, KY 40602

Phone: (502) 564-3296